STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 20, 21, 22, 23, 24, and 27, 2012 Facility number: 000105 Provider number: 155198 AIM number: n/a Survey team: Connie Landman RN TC Diana Zgonc RN Lora Brettnacher RN (February 20, 21, & 22, 2012) Census bed type: SNF: 86 Residential: 61 Total: 147 Census payor type: Medicare: 21 Other: 126 Total: 147 Stage 2 Sample: 29 Residential Sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this plan of correction does not constitute as an admission of any conclusion set forth in the statement of deficiencies or any violation of regulation(s).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review 3/01/12 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review and interview, the facility failed to ensure privacy of a resident's medical information by leaving the Medication Administration Record open and uncovered for 1 of 29 residents reviewed for privacy in a Stage 2 Sample of 29 (Resident #186).	F0164	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** While the nurse involved in the alleged incident did not follow best practices, the cart was always within line of site. The nurse observed the surveyor approach the cart and therefore	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During observation of the medication cart for the 1st floor Rehabilitation Unit on 2/27/12 at 9:40 A.M., the cart was unattended and the Medication Administration Record (MAR) was open to Resident # 186's medications. During an interview with LPN # 1 on 2/27/12 at 9:45 A.M., she indicated she was responsible for the rehab medication cart. She also indicated at that time, she should not have left the book open or the medications on top of the cart unattended. A current facility policy dated 1/1/05 and titled "General Guidelines for Administering Medication" and provided by the Director of Nursing on 2/27/12 at 12:30 P.M. indicated, "... Standards of Practice for medication administration: ... 6. Maintain privacy of medical records." 3.1-3(o)		the resident's information was never truly at risk. The medical administration record for resident #186 was immediately protected by the nurse involved in the alleged incident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. All licensed nurses and qualified medication aides (QMAs) will be re-educated regarding the residents' rights to personal privacy and confidentiality of his or her personal and clinical records. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The nurse involved in the alleged incident has been reprimanded in accordance with facility policy and re-educated regarding the residents' rights to personal privacy and confidentiality of his or her personal and clinical records. All licensed nurses and qualified medication aides (QMAs) will be re-educated regarding the residents' rights to personal privacy and confidentiality of his or her personal and clinical records. Continuing education will occur	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			with newly hired nurses and qualified medication aides (QMAs) and annually thereafter for all nurses and qualified medication aides (QMAs). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Nursing administration will complete random audits daily through March 31, 2012, randomly three times a week through April 30, 2012, and then weekly through May 31, 2012. Information gathered from the audits will be forwarded to the QA committee quarterly. See Attachment A, Medication Administration Audit Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, record review and interview, the facility failed to ensure accurate assessments were done for 1 of 13 residents reviewed for assessments in a Stage 2 sample of 29 (Resident #104).	F0272	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** As documented in this survey, Resident #104 demonstrated the ability “to fully open her hands and fingers”. She was screened	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Resident #104's record was reviewed on 2/23/12 at 9:40 A.M. Current diagnoses included, but were not limited to, hepatocellular carcinoma - metastatic, SDAT (senile dementia - Alzheimer's type), constipation, agitation/delirium, hepatic encephalopathy, Alzheimer's Disease, and depressive disorder. During the staff interviews on 2/22/12 at 10:00 A.M., LPN #2 indicated Resident #104 had contractures of both hands and received daily ROM (range of motion) exercises. The Quarterly MDS (Minimum Data Set) Assessment, dated 1/19/12, indicated upper and lower extremity (included (arms, wrists, hands, legs, ankles, and feet) ROM had no impairment. The Quarterly MDS Assessment, dated 10/25/11, indicated upper and lower extremity ROM- no impairment. The Significant Change MDS Assessment, dated 8/9/11, indicated upper and lower extremity ROM had no impairment.		on 2/28/12 by hospice occupational therapy, which provided this assessment: "During the evaluation, the resident actively opened hands with verbal cues. Therapist was able to gently range digits. There was no increased tone observed." The therapist recommended bilateral soft palm protectors and alternate use so patient is able to use right hand functionally for ADLs. Soft palm protectors were ordered, per hospice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit was completed to identify residents with limited range of motion and to ensure appropriate interventions are in place to increase range of motion and/ or prevent a decline in range of motion. Any residents demonstrating a decline or change in functional capacity were assessed for a significant change of condition and a comprehensive assessment was completed as indicated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The current care plans available in the record were all originated on 8/4/11. The care plans were printed on 1/26/12, which was the last care plan review date also. The current care plans did not address a contracture or splint or Range of Motion. During an interview with the Second Floor Unit Manager (UM) on 2/23/12 at 10:45 A.M., she indicated the resident did have contractures of both hands. During observation of Resident #104 on 2/23/12 at 10:50 A.M., Resident #104 was instructed by the UM to open her hands and fingers, which were in a closed position. The resident was able to fully open her hands and fingers, but needed some assistance of her right hand to open the left hand. The UM indicated the resident had arthritis in her hands, causing the enlarged knuckles, stiff joints and crooked fingers. At this time, the UM indicated the resident should be evaluated for exercises and possible splinting to prevent contractures and the risk for contractures should be addressed on the resident's care plan.		All residents will be assessed for range of motion upon admission, quarterly, and with any significant change of condition. Residents identified with significant changes will be discussed in the daily interdisciplinary team meeting to ensure interventions are in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** All residents will be assessed for range of motion upon admission, quarterly, and with any significant change of condition. Nursing administration will conduct audits to ensure appropriate reporting and referral for treatment has been completed for those residents in their assessment review period. Any residents exhibiting a decline in functional capacity will be referred to therapy for screening. Information gathered from the audits will be forwarded to the QA committee quarterly. See Attachment B, Comprehensive Assessment Audit Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current facility policy, dated 4/07 and last reviewed 2/12, titled "Rehabilitative Nursing Care", provided by the DON (Director of Nursing) on 2/27/12 at 8:30 A.M., indicated: "... Policy Statement: The facility will provide nursing care in order to (1) meet ADL (Activities of Daily Living) needs for those residents unable to carry out these activities; (2) prevent decline in positioning, ADLs or ROM; or (3) maintain or improve positioning, ADLs or ROM abilities.... Procedure: General rehabilitative nursing care is that which does not require the use of a Qualified Professional Therapist to render such care. 1. The goal of the facility's rehabilitative nursing care is designed to assist each resident to achieve and maintain an optimal level of self-care and independence through normal activities of daily living.... ... 4. Through the resident care plan, the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc." 3.1-31(c)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, record review, and interview, the facility failed to ensure care plans were developed for all areas of care needed, for 1 of 13 residents reviewed for care plans in a Stage 2 Sample of 29 (Resident #68). Findings include: Resident #68's record was reviewed on 2/24/12 at 1:05 P.M. Current diagnoses included, but were not limited to, sepsis, UTI (urinary tract infection), hypothyroidism, ARF	F0279	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #68 was not adversely affected by this alleged deficient practice. The resident's comprehensive care plan was reviewed and updated to reflect current interventions for restorative nursing and splint usage. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(acute renal failure), paraplegia with spasticity, urinary retention, depression, personality disorder, IBS (irritable bowel syndrome), OA (osteoarthritis), GERD (gastroesophageal reflux disease), and neurogenic bladder. During an interview with the first floor Unit Manager (UM) on 2/23/12 at 10:15 A.M., she indicated Resident #68 had contractures of her hands, received ROM exercises, and did not have splints. During interview and observation of Resident #68 on 2/21/12 at 1:30 P.M., the resident was not observed with splints in place. During observation and interview with the resident on 2/24/12 at 10:00 A.M., the resident did not have splints in place. During the interview, the resident indicated she had splints, but she only wore them at night. The splints were present in her wall cabinet. During interview with the UM on 2/24/12 at 10:15 A.M., she indicated she did not believe the resident had splints. The Occupational Therapy discharge		All residents have the potential to be affected by this alleged deficient practice. Residents requiring restorative nursing and/ or splints were identified during a facility-wide audit and their care plans were modified as indicated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Care plans for residents receiving restorative services will be reviewed and updated per the MDS schedule and as needed. Nursing administration and restorative staff will meet monthly to review and revise individual progress and plans of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Nursing administration will audit care plans for residents requiring restorative nursing and/ or splints. The audits will occur weekly for 4 weeks and monthly thereafter. Information gathered from the audits will be forwarded to the QA committee quarterly. See Attachment C, Care Plan Audit Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	note, dated 12/7/11, indicated an "appropriate hand/wrist splint for " bilateral upper extremities was "on order." A current physician's order, dated 10/30/11, indicated "passive ROM BLE (bilateral lower extremities) twice daily". An order, dated 12/4/11, indicated "passive ROM to BLE twice daily". Another order, dated 12/30/11. indicated "PROM to BLE twice daily". There was no physician's order for the use of a splint or exercises to the resident's hands. The current care plan, dated 12/21/11, addressed the intervention of PROM (passive ROM) bid (twice a day) under the problem of requires assistance with completing ADLs due to impaired mobility. Resident #68 was documented to be on a Restorative Program for her bilateral lower extremity exercises. Notes indicated the resident was cooperative with the exercise program. The current care plan lacked documentation of a goal or interventions for a Restorative Program.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The current care plan (dated 12/21/11) and Nurses Notes did not address or mention splints. During an interview with the first floor UM, on 2/24/12 at 3:05 P.M., she indicated therapy had indicated resident had refused their splints. The UM indicated she had spoken with resident just now concerning the splints. The resident indicated the splints came with her from her previous facility, and she puts them on herself every night. A current facility policy, dated 4/07 and last reviewed 2/12, titled "Rehabilitative Nursing Care", provided by the DON (Director of Nursing) on 2/27/12 at 8:30 A.M., indicated: "... Policy Statement: The facility will provide nursing care in order to (1) meet ADL (Activities of Daily Living) needs for those residents unable to carry out these activities; (2) prevent decline in positioning, ADLs or ROM; or (3) maintain or improve positioning, ADLs or ROM abilities.... ... 4. Through the resident care plan, the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-35(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure a rehabilitative or restorative exercise program was established for 1 of 3 residents reviewed for ROM (range of motion) of 4 who met the criteria for ROM services (Resident #104) Findings include: Resident #104's record was reviewed on 2/23/12 at 9:40 A.M. Current diagnoses included, but were not limited to, hepatocellular carcinoma - metastatic, SDAT (senile dementia - Alzheimer's type), constipation, agitation/delirium, hepatic encephalopathy, Alzheimer's Disease, and depressive disorder. During the staff interviews on 2/22/12 at 10:00 A.M., LPN #2 indicated Resident #104 had contractures of both hands and received daily ROM exercises.	F0318	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** As documented in this survey, Resident #104 demonstrated the ability "to fully open her hands and fingers". She was screened on 2/28/12 by hospice occupational therapy, which provided this assessment: "During the evaluation, the resident actively opened hands with verbal cues. Therapist was able to gently range digits. There was no increased tone observed." The therapist recommended bilateral soft palm protectors and alternate use so patient is able to use right hand functionally for ADLs. Soft palm protectors were ordered, per hospice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. All residents	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The current care plans available in the record were all originated on 8/4/11. The care plans were printed on 1/26/12, which was the last care plan review date also. The current care plans did not address a contracture or splint or Range of Motion, or a restorative program. During an interview with the Second Floor Unit Manager (UM) on 2/23/12 at 10:45 A.M., she indicated the resident did have contractures of both hands. During observation of Resident #104 on 2/23/12 at 10:50 A.M., Resident #104 was instructed by the UM to open her hands and fingers, which were in a closed position. The resident was able to fully open her hands and fingers, but needed some assistance of her right hand to open the left hand. The UM indicated the resident had arthritis in her hands, causing the enlarged knuckles, stiff joints and crooked fingers. At this time, the UM indicated the resident should be evaluated for exercises and possible splinting to prevent contractures and the risk for contractures should be addressed on the resident's care plan.		were assessed by restorative nursing staff to ensure that all residents with a limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be re-educated regarding the Rehabilitative Nursing Care Policy and Procedure, including the importance of reporting and/ or referring those residents demonstrating any decline or change in functional capacity. Residents identified with significant changes will be discussed in morning interdisciplinary team meetings to ensure interventions are in place and care plans are modified appropriately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** All residents will be assessed for range of motion upon admission, quarterly, and with any significant change of condition. Nursing administration will conduct audits to ensure appropriate reporting and referral for treatment has been completed for those residents in their assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current facility policy, dated 4/07 and last reviewed 2/12, titled "Rehabilitative Nursing Care", provided by the DON (Director of Nursing) on 2/27/12 at 8:30 A.M., indicated: "... Policy Statement: The facility will provide nursing care in order to (1) meet ADL (Activities of Daily Living) needs for those residents unable to carry out these activities; (2) prevent decline in positioning, ADLs or ROM; or (3) maintain or improve positioning, ADLs or ROM abilities.... Procedure: General rehabilitative nursing care is that which does not require the use of a Qualified Professional Therapist to render such care. 1. The goal of the facility's rehabilitative nursing care is designed to assist each resident to achieve and maintain an optimal level of self-care and independence through normal activities of daily living.... 3. Rehabilitative nursing care is performed as needed for those residents who require such service. Such care includes, but is not limited to:... ... f. Assisting residents with their routine range of motion exercises during activities of daily living.... ... 4. Through the resident care plan,		review period. Any residents exhibiting a decline in functional capacity will be referred to therapy for screening. Information gathered from the audits will be forwarded to the QA committee quarterly. See Attachment B, Comprehensive Assessment Audit Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc." 3.1-42(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview, the facility failed to ensure consents and education were provided for residents receiving the influenza vaccine for 5 of 5 residents reviewed for influenza vaccines in a Stage 2 sample of 29 (Resident # 102, # 104, # 81, # 43 and # 118). Findings include: The record lacked documentation of any consents or education for the influenza vaccines for the 2011 season for the following residents. All of the following residents received the	F0334	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility's policy and procedure for the Immunization Program has been revised to include annual education and consent of the resident or responsible party prior to administering the influenza vaccine. In the future, resident #'s 102, 104, 81, 43, and 118 will receive education and sign a new consent each year prior to receiving the influenza vaccine. **How other residents having the potential to be affected by the**	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	flu vaccine in the fall of 2011: The record for Resident # 102 was reviewed on 2/23/12 at 2:30 P.M. The last consent documented for Resident # 102 was 10/28/10. The record for Resident # 104 was reviewed on 2/23/12 at 9:40 A.M. The last consent documented for Resident # 104 was 9/23/10. The record for Resident # 81 was reviewed on 2/21/12 at 1:00 P.M. The last consent documented for Resident # 81 was 10/3/07. The record for Resident # 43 was reviewed on 2/21/12 at 2:00 P.M. The last consent documented for Resident # 43 was 10/10/10. The record for Resident # 118 was reviewed on 2/21/12 at 1:30 P.M. The last consent documented for Resident # 118 was 5/20/10. Consent and education documentation was requested for the influenza vaccines on 2/24/12 at 11:00 A.M. During an interview on 2/24/12 at 1:30 P.M. with the Director of Nursing, she indicated there was no further		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. The facility's policy and procedure for the Immunization Program has been revised to include annual education and consent of the resident or responsible party prior to administering the influenza vaccine. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nurses will be educated regarding the revised Immunization Program. Prior to administration,the facility will educate the resident or responsible party to the risk and benefits of the influenza vaccine and obtain a signed consent for the vaccine to be administered. This signed consent will be placed in the resident's medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Nursing administration will perform an audit prior to the annual influenza vaccination process to assure that consents have been received. The number of residents vaccinated and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	information, She also indicated they have never documented anything in the chart when the vaccine was given. 3.1-13(a)		number of declinations will be reviewedbythe QACommittee. See Attachment D, Influenza Roster.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure a resident's medications were locked away, for 1 of 8 medication	F0431	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cart observations (Resident # 186 and LPN #1). **Findings include:** During observation of the medication cart for the 1st floor Rehabilitation Unit on 2/27/12 at 9:40 A.M., the cart was unattended and the Medication Administration Record (MAR) was open to Resident # 186's medications, and medications were pre-set in a medication cup. During an interview with LPN # 1 on 2/27/12 at 9:45 A.M., she indicated she was responsible for the rehab medication cart. She also indicated at that time, the medications should not have been left on top of the medication cart unattended. A current facility policy dated 1/1/05 and titled "General Guidelines for Administering Medication" and provided by the Director of Nursing on 2/27/12 at 12:30 P.M. indicated, "... Procedure: Guidelines for handling medication: ... 4. Medications are administered at the time they are prepared. They are not pre-poured or pre-set in any manner. ... 6. ... No medication is kept on top of the cart or accessible to other		While the nurse involved in the alleged incident did not follow best practices, the cart was always within line of site. The nurse observed the surveyor approach the cart and therefore the resident's medication was never truly at risk. The medications for resident #186 were immediately secured by the nurse involved in the alleged incident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. All licensed nurses and qualified medication aides (QMAs) will be re-educated regarding the guidelines for medication administration and the facility policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The nurse involved in the alleged incident has been reprimanded in accordance with facility policy and re-educated regarding the guidelines for medication administration and the facility policy. All licensed nurses and qualified medication aides (QMAs) will be re-educated regarding the guidelines for medication administration and the facility policy. Continuing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents when the cart is unattended." 3.1-25(m)		education will occur with newly hired nurses and qualified medication aides (QMAs) and annually thereafter for all nurses and qualified medication aides (QMAs). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Nursing administration will complete random audits daily through March 31, 2012, randomly three times a week through April 30, 2012, and then weekly through May 31, 2012. Information gathered from the audits will be forwarded to the QA committee quarterly. See Attachment A, Medication Administration Audit Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	**What corrective action(s) will be accomplished for those**	03/28/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure a resident with physician's orders for contact isolation for Methicillin-resistant Staphylococcus Aureus (MRSA) in the nares remained in contact isolation until the order was discontinued, for 1 of 1 resident reviewed for contact isolation in a Stage 2 Sample of 29 (Resident # 182). Findings include: The record for Resident # 182 was reviewed on 2/23/12 at 2:50 P.M. Diagnoses for Resident # 182 included but were not limited to MRSA, End Stage Renal Disease and Diabetes. The resident was admitted on 2/17/12. A current physician's admission order dated 2/17/12, indicated a need for contact isolation and Vancomycin 500 milligrams intravenous at 60 milliliters per hour. A discharge note from the hospital on 2/17/12 indicated the resident required contact isolation due to MRSA. During an interview with the resident		**residents found to have been affected by the deficient practice:** Upon admission, a precautionary sign had been placed at the door of Resident #182. Staff were following standard precautions in the provision of his care. The facility policy entitled "Infection Control Guidelines for the Use of Precaution Signs" states that contact precautions require signage when there is a likelihood of visitors and/or staff coming into contact with blood or body fluids which are not contained. Resident #182 was exhibiting no nasal drainage and nursing administration was in process of consulting the attending physician regarding the actual need for isolation. Resident #182 no longer resides at the facility. It was determined by the attending physician prior to his discharge that this resident did not require contact precautions and the precautions were discontinued. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. A review of all medical records was completed. Appropriate signage is in place per policy for all residents identified with applicable infection. **What measures will be put into**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 2/20/12 at 10:45 A.M., he indicated he did not attend activities because he did not want to and he was in isolation so he preferred to stay in his room. Also during the interview an unknown visitor entered the resident's room and asked to speak to the resident at another time. While in the room the unknown visitor leaned against the end of the bed with their hand on the bed and then left. No gloves or gown was worn and no hand washing was observed. The resident's wife was also in the room without any protection on. Upon exiting the resident's room no sign was observed alerting staff or visitors to see the nurse prior to entering the resident's room. During an interview with LPN # 3 on 2/20/12 at 11:00 A.M., she indicated she did not know if the resident was on isolation precautions and would have to check his chart. After LPN # 3 reviewed his record, she indicated the resident did have orders for isolation precautions and there should be a sign on his door alerting visitors to see the nurse before entering the room. During an interview with the Director of Nursing (DON) on 2/23/12 at 1:00		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be re-educated to the facility's policy on "Infection Control Guidelines for the Use of Precaution Signs". Licensed nurses and qualified medication aides (QMAs) will be responsible to check for appropriate precautionary signage every shift and document on the applicable residents' treatment record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Nursing Administration will complete audits daily through March 31, 2012, three times a week through April 30, 2012, and then weekly through May 31, 2012. Information gathered from the audits will be forwarded to the QA Committee quarterly. See Attachment C, Precautionary Sign Audit Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., she indicated if they admit a resident that has MRSA, they follow the Dr's precautions and either put them in a room by themselves or they are cohorted with another resident with MRSA. They also post a sign on the door and staff lets management know if other visitors or staff are not complying with the precautions. During an interview with the DON and Rehab Unit Manager on 2/23/12 at 3:15 P.M., the Unit Manager indicated the nurses used isolation precautions over the weekend and the resident was placed in the isolation room. She also indicated at that time, they don't have to use a sign unless staff and visitors could come in contact with blood or body fluids. Further documentation was requested verifying the resident was not in need of contact isolation when he was admitted to the facility. As of the time of exit on 2/27/12 at 4:00 P.M., no further documentation was provided. A current undated facility policy titled "Infection Control Guidelines for Use of Precaution Signs" and provided by the Rehabilitation Unit Manager on 2/23/12 at 4:15 P.M. indicated, "Policy: Precaution signs are used to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	alert staff and visitors to conditions requiring special infection control practices, above and beyond Universal or Standard Precautions ... Standards: ... 3.c. Contact Precautions require signage when there is a likelihood of visitors and/or staff entering the room coming into contact with blood or body fluids which are not contained by a wound dressing or closed catheter system." 3.1-18(b)			